DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/13/12

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445343	A. BUILDING _____ B. WING _____	08/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT SOUTH PITTSBURG, THE	201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380

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F 000	INITIAL COMMENTS An annual recertification and complaint investigation #30229 and #30276, were completed on August 27, 2012, at The Bridge at South Pittsburg. Deficiencies were cited related to complaint investigation #30276 under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	**Disclaimer:** The Bridge at South Pittsburg does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil of criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dana Adams — Administrator — 9-19-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, facility investigation review and interview, the facility failed to maintain confidentiality of protected medical information for one resident (#59) of forty-five residents reviewed in Stage 2. The findings included: Resident #59 was readmitted to the facility on June 29, 2011, with diagnoses including Vascular Dementia, Chronic Kidney Disease and End Stage Chronic Obstructive Pulmonary Disease. Medical record review of a discharge Minimum Data Set assessment dated July 16, 2012, revealed the resident was moderately independent for daily decision making and required limited assistance with Activities of Daily Living. Review of facility policy, Protected Health Information (PHI), (undated) revealed "...PHI is anything that contains information about a resident's condition, treatment, or payment. ALWAYS keep PHI confidential...as a part of this facility's staff - part of your job is to make sure resident information remains confidential...don't discuss your residents with family or friends..." Review of a facility investigation dated July 20, 2012, revealed LPN #2 (Licensed Practical Nurse) violated the resident's right to privacy on July 16, 2012, by verbally divulging the resident's confidential medical information to a visitor	F 164	**F 164 Personal Privacy/Confidentiality of Records** The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. **Residents affected:** Resident #59 was discharged from this facility on 7/16/12 and an investigation was immediately initiated on confidentiality of records. The nurse involved was suspended pending the investigation and subsequently terminated from employment. **Residents potentially affected:** All residents have the potential to be affected by this cited practice related to HIPPA. HIPPA compliance education with all departments was initiated on 7/18/2012 by our medical records director. **Systemic measures:** Medical records director or designee will implement a patient identifier for all residents that will be applied to access their protected health information. The responsible party and or resident will be notified via phone or mail by 10/13/2012 by the medical records director or designee. Admissions director / designee will inform resident and/ or family of the identifier on admission. Medical records director/ designee will educate direct care staff on HIPPA compliance and identifier related to conversations in public areas regarding protected health information upon hire, annually and PRN. **Monitoring measures:** Interviews will be conducted with families and residents regarding HIPPA monthly x 3 months. Any concerns identified will be reported to the social services director and immediately corrected. HIPPA will be addressed in QA monthly x 3 months and upon occurrence thereafter.	10/13/12

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F 164	Continued From page 2 (room-mate's family member). The visitor was interviewed by the Administrator and Director of Nurses (DON), during the facility investigation, and confirmed on July 16, 2012, LPN #2 made a statement that included information regarding the resident's medications and medical condition. Continued review of the facility investigation of a statement by LPN #1 who was present in the resident's room on July 16, 2012, revealed confidential medical information for resident #59 had been disclosed in the presence of the room-mate's family member. Interview with LPN #1, on August 29, 2012, at 9:40 a.m., in the 200 hall, confirmed the statement had been written and signed by LPN #1 on July 20, 2012. continued interview confirmed the breech in confidentiality of medical information for resident #59 occured on July 16, 2012. Interview with the Administrator and the DON, on August 28, 2012, at 3:00 p.m., in the front lobby, confirmed LPN #2 failed to follow the facility policy regarding Health Information Portability and Accountability and violated resident #59's right to privacy by unnecessary disclosure of protected healthcare information. C/O #30276	F 164	**F 241 Dignity and Respect of Individuality** The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Residents affected:** Resident #52 shirt was immediately pulled down by the treatment nurse to cover the exposed skin. Resident #95 yellow arm band was removed and replaced with different identifier indicating fall risk on 8/27/12. A review was conducted on 8/27/12 on all residents with yellow arm bands. The yellow arm bands were replaced with new identifiers. **Residents potentially affected:** All residents have the potential to be affected by this cited practice related to dignity. The unit Manager informed staff of dignity concerns and reviewed and replaced all yellow arm bands of residents identified on 8/27/12 **Systemic measures:** SDC / designee will educate staff on resident dignity and new identifier on yellow arm bands. Department heads will perform walking rounds throughout the work week and report identified dignity issues to the administrator / designee during stand up meeting. New residents with yellow arm band identifier will be reviewed in a weekly interdisciplinary team meeting x 4 weeks and PRN to discuss need and continuance of the program by the interdisciplinary team. Concerns identified will be reported to social services for follow up. **Monitoring measures:** Social services director or designee will report dignity concerns and follow up to the administrator weekly x 8 weeks. Concerns will be addressed in monthly QA meeting x 2 months.	10/13/12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain dignity for two residents (#52, #95) of forty-five residents reviewed. The findings included: Resident #52 was admitted to the facility on November 3, 2004, and readmitted on October 22, 2010, with diagnoses including Alzheimer's Disease and Diabetes. Medical record review of the quarterly Minimum Data Set (MDS) dated May 26, 2012, revealed the resident had short and long term memory problems, severely impaired cognitive skills, and required extensive assistance of one person with dressing. Observation on August 27, 2012, at 10:20 a.m., revealed the resident propelling self in a wheelchair, down the hallway, with the right breast exposed from the bottom of the resident's shirt. Observation on August 27, 2012, at 10:22 a.m., revealed two staff members passed the resident in the hallway without adjusting the resident's clothing. Observation and interview on August 27, 2012, at 10:27 a.m., with the facility's treatment nurse, revealed the resident seated in a wheelchair in the hallway, and confirmed the resident's breast was exposed.	F 241		

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F 241	Continued From page 4 Resident #95 was admitted to the facility on November 14, 2011, with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Hypertension. Medical record review of the quarterly Minimum Data Set (MDS) dated May 23, 2012, revealed the resident was moderately intact for daily decision making, required extensive assistance with all Activities of Daily Living (ADL)'s, and no restraints in use. Observation on August 27, 2012, at 1:00 p.m., in the resident's room revealed a yellow arm band on the resident's left wrist and in capital black letters labeled "FALL RISK." Interview with the Nursing Home Administrator (NHA) on August 29, 2012, at 9:15 a.m., in the NHA's office, confirmed the yellow arm bands labeled fall risk did not maintain the resident's dignity and respect the resident's individuality.	F 241	**F 279 Develop Comprehensive Care Plans** A facility must use the result of the assessment to develop, review and revise the resident's comprehensive plan of care. **Residents Affected:** Resident #73 care plan was updated on 8/29/2012 to reflect her current visual status. **Residents potentially affected:** All residents have the potential to be affected by this cited practice related to vision. MDS coordinator will review 100% of residents with visual impairment to ensure care plan reflects their current status by 9/21/2012. **Systemic Measures:** SDC / designee will educate MDS personnel on updating care plans on residents with visual impairment to reflect their current status. The DON or designee will review 100% of care plans of residents with visual impairment weekly x 4 weeks then 25% monthly x 1 month based on MDS schedule. Any concerns will be addressed with the MDS office and care plan immediately updated. **Monitoring Changes:** Any identified concerns related to visual impairment not reflected on the care plan will be corrected immediately by the MDS coordinator and reported to the administrator. Concerns will be addressed in monthly QA x 3 months	10/13/12
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 5 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete a comprehensive care plan for one resident (#73) of twenty-four residents reviewed in stage two. The findings included: Resident #73 was admitted to the facility on July 16, 2009, and readmitted on May 20, 2010, with diagnoses including Senile Dementia, Diabetes Mellitus Type II, and Hypertension. Medical record review of the annual Minimum Data Set (MDS) dated July 23, 2012, revealed the resident was severely impaired for daily decision making, totally dependent for all Activities of Daily Living (ADL)'s, always incontinent of bowel and bladder, no swallowing problems, impaired vision, no glasses and has natural teeth that are broken. Medical record review of the care plan dated July 23, 2012, revealed no intervention to address vision. Interview with the MDS Coordinator #2 on August	F 279		

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F 279	Continued From page 6 29, 2012, at 9:00 a.m., in the MDS office, confirmed the care plan did not address impaired vision.	F 279	F 280 **Right to Participate Planning Care Revise CP**	10/13/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to evaluate and revise the care plan to reflect the resident's dialysis schedule for one resident (#95) of twenty-four residents reviewed in stage two. The findings included:	F 280	'The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in planning care and treatment or changes in care and treatment. **Residents affected:** Resident #95 care plan was updated on 8/29/2012 to reflect her current dialysis frequency **Residents potentially affected:** All residents have the potential to be affected by this cited practice related to dialysis frequency. . MDS coordinator will review 100% of residents receiving dialysis to ensure care plan reflects their current frequency by 9/21/2012. **Systemic measures:** SDC / designee will educate MDS personnel on updating care plans on residents receiving dialysis to reflect their current frequency The DON or designee will review 100% of care plans of residents receiving dialysis weekly x 4 weeks then 25% monthly x 1 month based on MDS schedule. Any concerns will be addressed with the MDS office and care plan immediately updated. **Monitoring measures:** Any identified concerns related to dialysis frequency not reflected on the care plan will be corrected immediately and reported to the administrator. Concerns will be addressed in monthly QA x 3 months	

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F 280	Continued From page 7 Resident #95 was admitted to the facility on November 14, 2011, with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Hypertension. Medical record review of the quarterly Minimum Data Set (MDS) dated May 23, 2012, revealed the resident was moderately impaired for daily decision making, and required extensive assistance for all activities of daily living (ADL)'s. Medical record review of the care plan dated August 24, 2012, revealed "...at risk for abnormal bleeding...treatment hemodialysis...assess access site upon returning from dialysis clinic for thrill bruit...check shunt site...daily and as needed and record on dialysis flow record..." Interview with the MDS Coordinator #1 on August 28, 2012, at 2:00 p.m., in the MDS office, confirmed the care plan had not been revised/updated to reflect the resident's current dialysis schedule to include frequency and days of the week.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide services that meet professional standards of quality by ensuring physician's orders for pain medication were followed for one resident (#187)	F 281	**F 281 services Provided Meet Professional Standards** 10/13/12 The services provided or arranged by the facility must meet professional standards of quality **Residents affected:** Resident # 187 was assessed for pain on 8/27/2012 and dosage checked for accuracy. NP was notified and new orders were obtained. Pharmacy was contacted and pain medications were delivered to facility. **Residents Potentially Affected:** All residents have the potential to be affected by this cited practice related to administering the correct dose of pain medication. The unit managers reviewed 100% of residents receiving pain medication on 8/27/2012 to ensure correct dose was being administered according to the physician orders. **Systemic Changes:** The ADON/designee will check all new pain medication orders with what was delivered by the pharmacy to ensure correct medication and dosage is at facility throughout the week. New pain medications will be added to the whiteboard process and reviewed in clinical meeting throughout the work week by the DON/designee. The ADON/designee will report to the DON / designee pain medications that did not reflect the current physician orders. The DON / designee will contact the pharmacy and/or the NP to verify and correct if a discrepancy is noted with medication dosage. **Monitoring Changes:** The DON/ designee will report dosage discrepancies to the administrator weekly x 8 weeks. The administrator will address and report monthly in QA x 2 months.	

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F 281	Continued From page 8 of twenty-four residents reviewed. The findings included: Resident #187 was admitted to the facility on August 21, 2012, with diagnoses including Status Post Above the Knee Amputee, Hypertension, and Cerebral Vascular Accident. Medical record review of a Physician's Telephone order dated August 21, 2012, at 1:30 p.m., revealed "...Percocet 10/325 mg 1 po q 6 hours as needed dispense 60..." Medical record review of a Controlled Drug Record issue date August 21, 2012, revealed "...Oxycodone-Acetaminophen 5-325 sub (substitute) for Percocet 5-25 mg tablet...qty (quantity): 60..." Medical record review of the Medication Administration Record (MAR) dated August 21, 2012, through August 31, 2012, revealed "...Percocet 10/325 tab (tablet) po q 6 hr (hour) as needed for pain..." Observation on August 27, 2012, at 1:30 p.m., in the resident's room, revealed the resident lying on the bed. Interview with Licensed Practical Nurse (LPN) #1 on August 29, 2012, confirmed the resident had an order for Percocet 10/325, the medication available from the pharmacy was Percocet 5/325, the pharmacy dispensed sixty, fifty tabs remained available for use, and the Percocet 10/325 was not available from the pharmacy.	F 281		

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F 281	Continued From page 9 Interview with the Director of Nursing (DON) on August 29, 2012, at 7:40 a.m., in the conference room, confirmed the facility failed to ensure professional standards of quality were provided by administering the correct dose of pain medication to the resident.	F 281	F 325 Maintain Nutrition Status Unless Unavoidable Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem.	10/12/12
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a therapeutic diet for one resident (#95) of four residents reviewed in stage two. The findings included: Resident #95 was admitted to the facility on November 14, 2011, with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Hypertension. Medical record review of the quarterly Minimum Data Set (MDS) dated May 23, 2012, revealed	F 325	**Residents Affected:** Resident #95 diet was immediately reviewed by the NP and RD and preferences were updated per resident's likes and dislikes by the certified dietary manager. **Residents Potentially Affected:** All residents have the potential to be affected by this cited practice regarding renal diets. Certified dietary manager will review 100% of all residents on a renal diet by 9-21-2012 for accuracy of therapeutic diet. **Systemic Changes:** Certified dietary manager / designee will educate dietary staff regarding renal diets and preferences. Certified dietary manager will complete tray accuracy audit weekly x 4 weeks to ensure therapeutic diet is followed per physician's order and preferences are considered. Any concerns with therapeutic diets or preferences will be addressed immediately by the CDM and reported to the DON/ designee in the clinical meeting throughout the week. **Monitoring changes:** The DON / designee will report any therapeutic diet, and preference concerns identified by the CDM on the audit to the administrator. The administrator / designee will report monthly in QA x 2 months.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445343	A. BUILDING _____ B. WING _____	08/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT SOUTH PITTSBURG, THE	201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380

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F 325	Continued From page 10 the resident was moderately intact for daily decision making, required extensive assistance with all Activities of Daily Living (ADL)'s, and no restraints in use. Medical record review of a Dietitian Progress Note dated August 21, 2012, revealed "...renal diet NCS (no concentrated sweets)...continues with dialysis..." Medical record review of the care plan dated August 24, 2012, revealed "...resident is at nutrition risk...diet as ordered - Renal NCS..." Medical record review of a Physician Recapitulation Orders dated August 2012, revealed "...Diet orders...Renal NCS diet potassium restrictions..." Observation on August 28, 2012, at 12:30 p.m., in the resident's room, revealed the resident sitting in a wheel chair eating lunch. Further observation at this time revealed the resident's plate contained pinto beans, bread, barbeque, and mashed potatoes. Continued observation of a diet card on the tray revealed "...food dislikes...navy beans...dried beans...mashed potatoes...potatoes...pinto beans...spicy foods..." Interview with the resident on August 28, 2012, at 12:35 p.m., confirmed the resident was on a renal diet and states "I'm not supposed to have this food." Interview and observation with the Dietary Manager on August 28, 2012, at 12:45 p.m., in the resident's room, revealed the diet card does not contain dislikes the list is food items not	F 325		

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F 325	Continued From page 11 allowed on a renal diet. Further interview at this time confirmed the facility failed to provide the resident a therapeutic renal diet.	F 325	**F 356 Posted Nurse Staffing Information**	10/13/12
F 356 SS=F	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	The facility must post the following information on a daily basis: Facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, Licensed practical nurses, Certified nurse aides with resident census. **Residents Affected and potentially affected:** All residents have the potential to be affected by this cited staffing deficiency. The posted daily nurses staffing sheet was corrected on 8/27/12 by SDC to reflect the correct nursing staff on duty **Systemic changes:** The DON/designee will post the daily nursing staffing sheet each day to reflect the correct nurse staffing data. Each nurses station will have their own staffing sheet that will be updated by the ADON/charge nurse in the event of a scheduling change. The DON/designee throughout the work week will review nurse staffing sheet for accuracy. Staffing concerns identified on the posted sheet will be addressed with ADON/charge nurse on that unit and corrected by them. The Staff development coordinator will educate licensed staff on posted nurse staffing information and documentation with changes. **Monitoring changes:** The DON/designee will report any staffing data concerns identified in the clinical meeting throughout the work week. Identified concerns will be reported to the administrator / designee weekly and addressed in monthly QA x 2 months and upon occurrence thereafter.	

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F 356	Continued From page 12 by: Based on review of facility documentation and interview the facility failed to post the correct nurse staffing data. The findings included: Observation and review of the posted nurse staffing and interview on initial tour with Registered Nurse (RN) #1 on August 27, 2012, at 10:30 a.m., revealed the posted nurse staffing indicated four RN's, five Licensed Practical Nurses (LPN), and fifteen Certified Nurse Aides currently on duty. Review of the facility's posted nurse staffing and interview on August 27, 2012, at 10:50 a.m., with RN #1 in the hallway, revealed the posted nurse staffing currently was two RNs, six LPNs, and thirteen CNAs and confirmed the posted nurse staffing on initial tour was not accurate.	F 356	**F 428 Drug Regimen Review, Report Irregular, Act on** The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. **Residents Affected:** Resident # 29 medication times were reviewed by the facility NP with no changes noted due to resident's history of non-compliance with medications. The pharmacist recommendation form was completed by the NP and placed in the chart by the DON. **Residents potentially affected:** All residents have the potential to be affected by this cited pharmacy consultant deficiency. 100% of all pharmacy consultant reports for July and August are being reviewed by the unit managers to ensure compliance with recommendations and completed by 9/21/2012. **Systemic changes:** The DON/designee will receive all pharmacy recommendations from the pharmacist following their visit. The DON/designee will make a copy of the recommendations and will initial and date when the recommendations are signed by the MD/NP and returned to the facility. The DON/designee will place pharmacy recommendations on their whiteboard process for tracking until all recommendations have been returned for the current month. **Monitoring changes:** The DON/designee will report any issues identified with pharmacy recommendations not being returned and will set up a meeting with the physician. Any issues with pharmacy recommendation follow-up will be addressed in the monthly QA x 2 months and then upon occurrence thereafter.	10/13/12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		

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F 428	Continued From page 13 Based on review of the Monthly Pharmacist Report and interview, the facility failed to follow pharmacy recommendations for one (#29) of ten residents reviewed. The findings included: Resident #29 was admitted to the facility on March 11, 2009, and readmitted on October 7, 2011, with diagnoses including Dementia with Behavioral Dyscontrol, Seizure Disorder, Depression, Chronic Obstructive Pulmonary Disease, Cerebral Palsy, Anxiety, Obsessive Complusive Disorder, Late Effects Acute Polio, and Colostomy. Review of the Monthly Pharmacist Report dated July 2012, revealed "...A drug interaction between Dilantin (anti-seizure medication) and Calcium (dietary supplement) has been noted. The use of these two medications together may decrease Dilantin absorption. Please consider giving Dilantin 2 hrs (hours) before, or after, Calcium..." Medical record review of the August 1-27, 2012, Medication Record revealed the resident received Calucium Carbonate 1250 mg (milligrams) by mouth twice daily at 9:00 a.m., and 8:00 p.m. Continued review of the August 1-27, 2012, Medication Record revealed the resident received Phenytoin (Dilantin) twice daily at 9:00 a.m. and 8:00 p.m. Medical record review of the nursing notes dated July 6, 2012 through August 28, 2012, revealed no documentation of seizure activity. Observation on August 28, 2012, at 2:05 p.m.,	F 428		

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F 428	Continued From page 14 revealed the resident seated in a wheelchair in the resident's room, drinking tea and watching television. Interview on August 28, 2012, at 3:30 p.m., with the Director of Nursing in the conference room, confirmed the July 2012 pharmacy recommendations to change the administration times of the Dilantin and Calcium had not been followed.	F 428		